

\$30/\$2,700 DEDUCTIBLE PLAN WITH HSA

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside your Home Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, visiting Member care, hospice care, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

“Kaiser Permanente \$2,700 Deductible Plan with HSA Option” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *EOC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

ANNUAL OUT-OF-POCKET MAXIMUM

You will not pay any more Cost Sharing during a calendar year after the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to one of the following amounts:

For self-only enrollment (a Family Unit of one Member)	\$5,250 per calendar year
For any one Member in a Family Unit of two or more Members	\$5,250 per calendar year
For an entire Family Unit of two or more Members Deductible	\$10,500 per calendar year

for all Services except certain preventive Services as specified below

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

For self-only enrollment (a Family Unit of one Member)	\$2,700 per calendar year
For any one Member in a Family Unit of two or more Members	\$2,700 per calendar year
For an entire Family Unit of two or more Members	\$5,450 per calendar year

Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

LIFETIME MAXIMUM

None

PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)

	YOU PAY
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$30 per visit after Deductible
Routine preventive physical exams	\$30 per visit (Deductible doesn't apply)
Well-child preventive care visits (0–23 months)	\$10 per visit (Deductible doesn't apply)
Family planning visits	\$30 per visit after Deductible
Scheduled prenatal care	\$10 per visit (Deductible doesn't apply)
Routine preventive refraction exams	\$30 per visit after Deductible
Routine preventive hearing tests	\$30 per visit after Deductible
Physical, occupational, and speech therapy visits	\$30 per visit after Deductible

OUTPATIENT SERVICES

	YOU PAY
Outpatient surgery	30% Coinsurance after Deductible
Allergy injection visits	\$5 per visit after Deductible
Allergy testing visits	\$30 per visit after Deductible
Vaccines (immunizations)	No charge (Deductible doesn't apply)
X-rays and lab tests	\$10 per encounter after Deductible (except the Deductible doesn't apply to preventive screenings as described in the <i>EOC</i>)
MRI, CT and PET	\$50 per procedure after Deductible
Health education: Individual visits	\$30 per visit after Deductible

Group educational programs	No charge after Deductible (except the Deductible doesn't apply to tobacco-cessation programs)
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HOSPITALIZATION SERVICES Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	YOU PAY 30% Coinsurance after Deductible
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EMERGENCY HEALTH COVERAGE Emergency Department visits	YOU PAY 30% Coinsurance after Deductible
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AMBULANCE SERVICES Ambulance Services	YOU PAY \$100 per trip after Deductible
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PRESCRIPTION DRUG COVERAGE Most covered outpatient items in accord with our drug formulary guidelines: Generic items from a Plan Pharmacy Generic refills from our mail-order program Brand-name items from a Plan Pharmacy Brand-name refills from our mail-order program	YOU PAY \$10 for up to a 30-day supply, \$20 for a 31 to 60-day supply, or \$30 for a 61 to 100-day supply after Deductible \$20 for up to a 100-day supply after Deductible \$30 for up to a 30-day supply, \$60 for a 31 to 60-day supply, or \$90 for a 61 to 100-day supply after Deductible \$60 for up to 100-day supply after Deductible
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DURABLE MEDICAL EQUIPMENT (DME) The DME items for home use listed in the EOC in accord with our DME formulary guidelines (most DME items are not covered)	YOU PAY 20% Coinsurance after Deductible
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MENTAL HEALTH SERVICES Inpatient psychiatric care (up to 30 days per calendar year) Outpatient visits: Up to a total of 20 individual and group therapy visits per calendar year Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the EOC.	YOU PAY 30% Coinsurance after Deductible \$30 per individual therapy visit after Deductible \$15 per group therapy visit after Deductible \$15 per group therapy visit after Deductible
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CHEMICAL DEPENDENCY SERVICES Inpatient detoxification Outpatient individual therapy visits Outpatient group therapy visits Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	YOU PAY 30% Coinsurance after Deductible \$30 per visit after Deductible \$5 per visit after Deductible \$100 per admission after Deductible
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HOME HEALTH SERVICES Home health care (up to 100 visits per calendar year)	YOU PAY No charge after Deductible
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OTHER Skilled nursing facility care (up to 100 days per benefit period) Hospice care	YOU PAY 30% Coinsurance after Deductible No charge after Deductible
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This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Introduction

Welcome to Kaiser Permanente

When you join Kaiser Permanente, you get a health plan that's dedicated to your total well-being.

Our healthy living (health education) programs offer you great ways to protect and improve your health. You get a wealth of information online with **kp.org**. Save time in requesting routine appointments and prescription refills. Use the extensive health and drug encyclopedias to learn more about your health. Find Plan Facilities and providers close to home or work.

When you need medical care, we've got you covered. You can have a personal physician who understands your lifestyle. You can often take care of many health needs at one place, in one trip--from office visits to lab work, pharmacy, and X-rays. Most of our facilities provide same-day Urgent Care appointments, and many have evening and weekend appointments. And, you're not limited to receiving care from just one facility; you pick the Plan Facility that's most convenient for you. If you need specialty care, you have access to a wide array of medical specialties. You can even self-refer to selected specialties. And you can depend on the security of emergency coverage anywhere in the world.

We are committed to investing first and foremost in your health. From routine checkups to online services to Emergency Care, you can count on us to help you stay healthy.

About this booklet

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage. ***Please read the following information so that you will know from whom or what group of providers you may obtain health care. Also, you should read this Disclosure Form and the Evidence of Coverage carefully if you have special health care needs.***

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Service Areas in California (the Northern California or Southern California Region), which we call your "Home Region." Your group's benefits administrator can tell you which California Region is your Home Region. This *Disclosure Form* describes your coverage in your Home Region. Also, this *Disclosure Form* describes different benefit plans, for example benefit plans that include Deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated.

Please see the Health Plan Benefits and Coverage Matrix for a summary of Deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Call Center toll free at **1-800-464-4000** or refer to your *Evidence of Coverage*.

Some capitalized terms have special meaning in this *Disclosure Form*, as described in the "Definitions" section at the end of this booklet.

Evidence of Coverage: To obtain an *Evidence of Coverage*, please contact your group benefits administrator. Your *Evidence of Coverage* provides details about the terms and conditions of your

coverage, including exclusions and limitations. Also, you have the right to review one before enrolling. This *Disclosure Form* is only a summary.

Note: State law requires disclosure form documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Call Center toll free at **1-800-464-4000**, to ensure that you can obtain the health care services that you need."

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Kaiser Permanente Deductible Plan with HSA Option

"Kaiser Permanente Deductible Plan with HSA Option" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *Evidence of Coverage* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

The tax references contained in this *Disclosure Form* relate to federal income tax only. The tax treatment of Health Savings Account (HSA) contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Health Plan does not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for a Health Savings Account.

Please be aware that enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. Some examples of other requirements include that you must not be:

- Covered by another health coverage plan that is not also an HSA-compatible plan, with certain exceptions
- Entitled to Medicare Part A or B
- Able to be claimed as a dependent on another person's tax return

How to obtain care

Our Members receive covered medical care from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) inside your Home Region's Service Area at Plan Facilities except as described in this *Disclosure Form* or the *Evidence of Coverage* for the following Services listed below:

- Authorized referrals
- Emergency ambulance Services
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care
- Hospice care
- Visiting Member care

For Plan Facility locations, please refer to the enclosed facility listing, *Your Guidebook to Kaiser Permanente Services*, our Web site at **kp.org**, or your local telephone book under "Kaiser Permanente."

Emergency Care and Post-stabilization Care from Non-Plan Providers

Emergency Care. If you have an Emergency Medical Condition, call **911** or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care anywhere in the world.

An Emergency Medical Condition is: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Note: For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department listed in *Your Guidebook* if you are inside your Home Region's Service Area, but only if it is reasonable to do so, considering your condition or symptoms.

Post-stabilization Care. Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-stabilization Care from a Non-Plan Provider, including inpatient care at a Non-Plan Hospital, only if we provide prior authorization for the care (prior authorization means that we must approve the Services in advance for the Services to be covered).

To request authorization to receive Post-stabilization Care from a Non-Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call **711**) or the notification telephone number on your ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Be sure to ask the Non-Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover unauthorized Post-stabilization Care or related transportation provided by Non-Plan Providers.

Please refer to your *Evidence of Coverage* for coverage information, exclusions, and limitations.

Out-of-Area Urgent Care from Non-Plan Providers

If you have an Urgent Care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non-Plan Provider if all of the following are true:

- You receive the Services from Non-Plan Providers while you are temporarily outside your Home Region's Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region's Service Area

Your identification card

Each Member's Kaiser Permanente identification card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your Kaiser Permanente ID and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call our Member Service Call Center if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

If you need to get care before you receive your ID card, please ask your group benefits administrator for your group (purchaser) number, your Home Region, and the date your coverage became effective. This information will be helpful if you need care before receiving your ID card.

Plan Facilities and *Your Guidebook to Kaiser Permanente Services*

At most of our Plan Facilities, you can usually receive all the covered Services you need, including Emergency Care, Urgent Care, specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you. For facility locations, please refer to the enclosed facility listing or call our Member Service Call Center toll free at **1-800-464-4000**.

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Care is available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same-day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. *Your Guidebook* also explains how to use our Services and make appointments, lists hours of operations, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities.

Your Guidebook is subject to change and periodically updated. We will mail you *Your Guidebook* after you've enrolled. If you do not receive a copy or need another copy, call our Member Service Call Center toll free at **1-800-464-4000** or **1-800-777-1370** (TTY for the deaf, hard of hearing or speech impaired), weekdays 7 a.m. to 7 p.m. and weekends 7 a.m. to 3 p.m. (except holidays). You can also download a copy from our Web site at **kp.org**.

Your primary care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan

Physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center toll free at **1-800-464-4000**. You can find a directory of our Plan Physicians on our Web site at **kp.org**.

Getting a referral

Referrals to Plan Providers

Primary care. Primary care Plan Physicians provide primary medical care, including pediatric care and obstetrics/gynecology care. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, family medicine, obstetrics/gynecology, family planning, and pediatrics.

Specialty care. Plan Physicians who are specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician must refer you before you can be seen by one of our specialists except that you do not need a referral to receive care in the following areas: optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't require a referral.

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by the Medical Group for the Services to be covered (prior authorization means that the Medical Group must approve the Services in advance for the Services to be covered):

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non-Plan Provider inside or outside your Home Region's Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non-Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Bariatric surgery.** If you are a Southern California Region Member and your Plan Physician makes a written referral for bariatric surgery, the Medical Group's regional bariatric medical director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary. The Medical Group's criteria for determining whether bariatric surgery is Medically Necessary are described in the Medical Group's bariatric surgery referral criteria, which are available upon request
- **Durable medical equipment (DME).** If your Plan Physician prescribes a DME item, he or she will submit a written referral to the Plan Hospital's DME coordinator, who will authorize the DME item if he or she determines that your DME coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our DME formulary guidelines, then the DME coordinator will contact the Plan Physician for additional information. If the DME request still doesn't appear to meet our DME formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our DME formulary, please refer to the *Evidence of Coverage*

- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Evidence of Coverage*
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information and other Services that are subject to an authorization procedure, please refer to the *Evidence of Coverage* or call our Member Service Call Center toll free at **1-800-464-4000**.

Second opinions

If you request a second opinion, it will be provided to you when Medically Necessary by an appropriately qualified medical professional. You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Physician. For more information, please refer to the *Evidence of Coverage*.

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please ask your Plan Physician or call our Member Service Call Center toll free at **1-800-464-4000**.

Your costs

Cost Sharing (Deductibles, Copayments, and Coinsurance)

When you receive covered Services, you must pay your Cost Sharing amount as described in your *Evidence of Coverage* at the time you receive the Services.

For items ordered in advance, you may have to pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing before the item is ordered.

Note: In some cases, we may agree to bill you for your Cost Sharing amount.

Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in the Health Plan Benefits and Coverage Matrix. Please refer to the "Benefits and Cost Sharing" section of your *Evidence of Coverage* for the complete list of Copayments and Coinsurance.

Deductibles

In any calendar year, you must pay Charges for most Services until you meet the annual out-of-pocket maximum or the Deductible listed in the *Health Plan Benefits and Coverage Matrix*.

If the *Health Plan Benefits and Coverage Matrix* includes a Deductible for any one Member in a Family Unit of two or more Members, and if you are a Member in a Family Unit of two or more Members, you reach the Deductible either when you meet the Deductible for any one Member in a Family Unit of two or more Members, or when your Family Unit reaches the Family Unit Deductible. After you meet the annual out-of-pocket maximum or the Deductible and for the remainder of that calendar year, you pay the applicable Copayment or Coinsurance for Services subject to the Deductible. Each other member in your Family Unit must continue to pay Charges during the calendar year until either he or she reaches the Deductible for any one Member in a Family Unit of two or more Members, or your Family Unit reaches the Family Unit Deductible.

All covered Services are subject to the Deductible, except for certain preventive care Services described below. The only payments that count toward the Deductible are those you make for covered Services that are subject to the Deductible. When you pay a Deductible amount for a Service, we will give you a receipt. We will also send you a statement summarizing the amounts you have paid toward your Deductible and reaching the annual out-of-pocket maximum. You can also obtain a copy of this statement from our Deductible Products Service Team at **1-800-390-3507**. Please refer to your *Evidence of Coverage* for more information about Deductibles.

Preventive care Services. We cover a variety of preventive care Services, which are Services to help keep you healthy or to prevent illness. This "Preventive care Services" section explains which preventive care Services are not subject to the Deductible, but it does not otherwise explain coverage. These preventive care Services remain subject to the Cost Sharing and all other coverage requirements as described in the *Evidence of Coverage*.

The preventive care Services listed below are not subject to the Deductible, unless the Services are intended to diagnose or treat an existing illness, injury, or condition that has already been diagnosed or for which you have symptoms. Any other Services you receive during a preventive care exam will be subject to the Deductible.

The following preventive care is exempt from the Deductible:

- Flexible sigmoidoscopies
- Vaccines
- Mammograms
- Retinal photography screenings
- Routine preventive physical exams, including well-woman visits

- Scheduled prenatal visits
- Tobacco cessation programs
- Tuberculosis tests
- Well-child preventive care visits (0-23 months)
- The following laboratory tests:
 - ◆ cervical cancer screening including screening for HPV
 - ◆ cholesterol tests (lipid profile and panel)
 - ◆ diabetes screening (fasting blood glucose tests)
 - ◆ fecal occult blood tests
 - ◆ HIV tests
 - ◆ prostate specific antigen tests
 - ◆ STD tests

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay in a calendar year for all of the covered Services you receive in the same calendar year. The limit amounts are specified in the *Health Plan Benefits and Coverage Matrix*.

If your *Health Plan Benefits and Coverage Matrix* includes an annual out-of-pocket maximum for any one Member in a Family Unit of two or more Members, and if you are a Member in a Family Unit of two or more Members, you reach the annual out-of-pocket maximum either when you meet the annual out-of-pocket maximum for any one Member in a Family Unit of two or more Members, or when your Family Unit reaches the Family Unit maximum. Each other member in your Family Unit must continue to pay Cost Sharing during the calendar year until either he or she reaches the maximum for any one Member in a Family Unit of two or more Members, or your Family Unit reaches the Family Unit maximum. Please refer to your *Evidence of Coverage* for more information about annual out-of-pocket maximums.

We will send you a monthly statement of the amounts you have paid, including the amount you have paid toward reaching your annual out-of-pocket maximum.

Payment of Premiums

Your group is responsible for paying Premiums. If you are responsible for any contribution to the Premiums, your group will tell you the amount and how to pay your group (through payroll deduction, for example).

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services you obtain from Plan Providers or Non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. In some cases, you may be eligible to receive Services from a terminated provider in accord with applicable law. Please refer to "Completion of Services from Non-Plan Providers" in the "Miscellaneous notices" section for more information.

Reimbursement for Emergency, Post-stabilization, or Out-of-Area Urgent Care

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider, you must pay for the Services unless the Non-Plan Provider agrees to bill us. If you want us to pay for the Services you must file a claim. We will reduce any payment we make to you or the Non-Plan Provider by applicable Cost Sharing.

To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Call Center toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non-Plan Provider
- To request that a Non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non-Plan Provider. If the Non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non-Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Service Call Center toll free at **1-800-390-3510** for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim

Please refer to your *Evidence of Coverage* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

Termination of benefits

Your group is required to inform the Subscriber of the date your membership terminates except as otherwise noted.

You will be billed as a non-Member for any Services you receive after your membership terminates.

Membership will cease for you (the Subscriber) and your Dependents if:

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage as described in your *Evidence of Coverage*
- You commit one of the following acts, we may terminate your membership immediately by sending written notice to the Subscriber, termination will be effective on the date we send the notice, and you will not be allowed to enroll in Health Plan in the future:
 - ◆ your behavior threatens the safety of Kaiser Permanente personnel or of any person or property at a Plan Facility
 - ◆ you commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
 - ◆ you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider

- Your group fails to pay us the appropriate Premiums for your Family Unit

Please refer to the *Evidence of Coverage* for more information.

Continuation of membership

Continuation of group coverage

You may be able to continue your group coverage for a limited time after you would otherwise lose eligibility, if required by law under COBRA or Cal-COBRA. Please refer to the *Evidence of Coverage* for more information.

If at any time you become entitled to continuation of group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely. Note: Medical history does not impact premiums or eligibility for our individual plan described under "Converting from group membership to an individual plan" in this section. However, the individual plan premiums and coverage are different from the premiums and coverage under your group plan.

If you are called to active duty in the uniformed services, you may be able to continue your coverage for a limited time after you would otherwise lose eligibility, if required by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Please contact your group if you want to know how to elect USERRA coverage and how much you must pay your group.

Converting from group membership to an individual plan

You may be eligible to convert to our nongroup Individual–Conversion Plan if you no longer meet the eligibility requirements described in the *Evidence of Coverage*, or if you enroll in COBRA, Cal-COBRA, or USERRA continuation coverage and then lose eligibility for that coverage. We must receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

For information about converting your membership or about other individual plans, please refer to the *Evidence of Coverage*, or call our Member Service Call Center toll free at **1-800-464-4000**.

Getting assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your primary care Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at **1-800-464-4000** or **1-800-777-1370** (TTY for the deaf,

hard of hearing, or speech impaired). For your convenience, you can also contact us through our Web site at **kp.org**.

Member Service representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim.

Dispute resolution and binding arbitration

Member Service representatives at our Plan Facilities or Member Service Call Center can help you with unresolved issues. They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at **kp.org**. You must submit your grievance within 180 days of the date of the incident.

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services or payment of Services, and that either (1) our denial was based on a finding that the Services are not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at **1-888-HMO-2219** for assistance.

Except for Small Claims Court cases and, if your group must comply with Employee Retirement Income Security Act (ERISA), certain benefit-related disputes, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

This is a brief summary of dispute resolution options. Please refer to your *Evidence of Coverage* for more information, including the complete arbitration provision.

Renewal provisions

Your group is responsible for informing you when its contract with Kaiser Permanente is changed or terminated. The contract generally changes each year, or sooner if required by law.

Principal exclusions, limitations, and reductions of benefits

Exclusions

The following are the principal exclusions from coverage. See your *Evidence of Coverage* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular benefit are listed in the description of that benefit in your *Evidence of Coverage*.

- Care in a licensed intermediate care facility, except for covered hospice care
- Chiropractic Services, unless otherwise stated in your *Evidence of Coverage*
- Artificial insemination, unless otherwise stated in your *Evidence of Coverage*, and conception by artificial means
- Cosmetic Services, except for Services covered under “Reconstructive Surgery” and “Prosthetic and Orthotic Devices” in the *Evidence of Coverage*
- Custodial care, except for covered hospice care
- Dental care and dental X-rays
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies
- Experimental or investigational Services, except as required by law for certain cancer clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the *Evidence of Coverage* for details about independent medical review and other dispute resolution options)
- Eyeglasses, contact lenses, and contact lens eye examinations, unless otherwise stated in your *Evidence of Coverage*
- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Hearing aids, unless otherwise stated in your *Evidence of Coverage*
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary
- Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
- Services related to the diagnosis and treatment of infertility, unless otherwise stated in your *Evidence of Coverage*
- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development, unless Medically Necessary
- Transgender surgery
- Travel and lodging expenses
- Treatment of hair loss or growth

Limitations

We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme

circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care and Post-stabilization Care from Non-Plan Providers" in the "How to obtain care" section and we will provide coverage as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in your *Evidence of Coverage*.

Reductions

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Reductions" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. Alternatively, we may file a subrogation claim on our own behalf against the third party. In addition to these third party liability claims by Kaiser Permanente, the contracts between Kaiser Permanente and some providers may allow these providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and the fees the provider charges to the general public for the Services you received.

Please refer to your *Evidence of Coverage* for additional information and other reductions (for example, surrogacy arrangements and workers' compensation).

To become a Member

We look forward to welcoming you as a Kaiser Permanente Member. If you are eligible to enroll, simply return a completed enrollment application to your group benefits administrator. Be sure to ask your benefits administrator for your group (purchaser) number, your Home Region, and the date when your coverage becomes effective. You can begin using our Services on your effective date of coverage. Again, if you have any questions about Kaiser Permanente, please call our Member Service Call Center toll free at **1-800-464-4000** or you can refer to the *Evidence of Coverage* for details about eligibility requirements.

Miscellaneous notices

Completion of Services from Non-Plan Providers

New Member. If you are currently receiving Services from a Non-Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non-Plan Provider's Services.

Terminated provider. If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility. The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- We may cover Services for serious chronic conditions until the earlier of (i) 12 months from your membership effective date if you are a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the first day after a course of treatment is complete, when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non-Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
 - ◆ it persists without full cure
 - ◆ it worsens over an extended period of time
 - ◆ it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (i) 12 months from the child's membership effective date if the child is a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Service
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non-Plan Provider on your membership effective date if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non-Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside your Home Region's Service Area
- The Services to be provided to you would be covered Services under your *Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your membership effective date if you are a new Member, or from the termination date of the Plan Provider

The Cost Sharing for completion of Services is the Cost Sharing required for Services provided by a Plan Provider as described in the *Evidence of Coverage*. **For more information about this**

provision and to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Call Center.

Drug formulary

Our drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members in your Home Region's Service Area. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like to request a copy of our drug formulary, please call our Member Service Call Center.

Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance as described in the *Evidence of Coverage*. Also, our formulary guidelines may require you to participate in a Medical Group–approved behavioral intervention program for specific conditions, and you may be required to pay for the program.

Please refer to the Health Plan Benefits and Coverage Matrix to learn if you have coverage for outpatient prescription drugs.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll free at **1-800-434-0222** (TTY users call **711**), for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our Web site at kp.org.

Definitions

Charges: Charges means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of the Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in the *Health Plan Benefits and Coverage Matrix*. For the complete list of Copayments and Coinsurance, please refer to your *Evidence of Coverage*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service. Note: The dollar amount of the Copayment can be \$0 (no charge). A summary of Copayments and Coinsurance is listed in the *Health Plan Benefits and Coverage Matrix*. For the complete list of Copayments and Coinsurance, please refer to your *Evidence of Coverage*.

Cost Sharing: The amount you are required to pay for a covered Service, for example, a Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for most Services before we will cover those Services at the Copayment or Coinsurance in that calendar year. Deductible amounts are listed in the *Health Plan Benefits and Coverage Matrix*.

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *Evidence of Coverage*.

Emergency Care: Emergency Care is:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine whether you have an Emergency Medical Condition
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the *Evidence of Coverage*

Emergency Medical Condition: An Emergency Medical Condition is (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Family Unit: A Subscriber and all of his or her Dependents.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *Disclosure Form* sometimes refers to Health Plan as "we" or "us."

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223 (d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law eligibility requirements.

Health Plan does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan: A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage summarized in this *Disclosure Form* has been designed to be a High Deductible Health Plan compatible for use with a Health Savings Account.

Home Region: Health Plan's Northern California Region or Southern California Region where you are enrolled under the *Group Agreement* between Kaiser Foundation Health Plan, Inc., and your group.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: For Northern California Region Members, The Permanente Medical Group, Inc., a for-profit professional corporation, and for Southern California Region Members, the Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: A federal health insurance program for people age 65 and older, and some people under age 65 with disabilities or end-stage renal disease (permanent kidney failure). In this *Disclosure Form*, Members who are “eligible for” Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who are “entitled to” or “have” Medicare Part A or B are those who have been granted Medicare Part A or B coverage. If you have Medicare Part A or B, you are ineligible to establish or contribute to a Health Savings Account.

Member: A person who is eligible and enrolled, and for whom we have received applicable Premiums. This *Disclosure Form* sometimes refers to a Member as "you."

Non-Plan Hospital: A hospital other than a Plan Hospital.

Non-Plan Physician: A physician other than a Plan Physician.

Non-Plan Provider: A provider other than a Plan Provider.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child’s) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside your Home Region's Service Area
- You reasonably believed that your (or your unborn child’s) health would seriously deteriorate if you delayed treatment until you returned to your Home Region's Service Area

Plan Facility: Any facility listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Call Center.

Plan Hospital: Any hospital listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Call Center.

Plan Medical Office: Any medical office listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Call Center.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your Home Region's Service Area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Call Center.

Plan Physician: Any licensed physician who is a partner or an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members in your Home Region's Service Area (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that we designate as a Plan Provider in your Home Region's Service Area.

Post-stabilization Care: Post-stabilization Care is Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

Premiums: Periodic membership charges paid by your group.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center toll free at **1-800-464-4000**.

Service Area: For Members enrolled in the **Northern California Region**, the following counties are entirely inside our Northern California Region Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Also, portions of the following counties are inside our Northern California Region Service Area, as indicated by the ZIP codes below for each county:

- Amador: 95640, 95669
- El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–80, 93784, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558–59, 94562, 94567*, 94573–74, 94576, 94581, 94589–90, 94599, 95476
- Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765

- Santa Clara: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- Sonoma: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95837
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

*Exception: Knoxville is not in the Northern California Region Service Area.

For Members enrolled in the **Southern California Region**, Orange County is entirely inside our Southern California Region Service Area. Also, portions of the following counties are inside our Southern California Region Service Area, as indicated by the ZIP codes below for each county:

- Imperial: 92274–75
- Kern: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93250–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- Los Angeles: 90001–84, 90086–89, 90091, 90093–96, 90099, 90101–03, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–13, 90397–98, 90401–11, 90501–10, 90601–10, 90612, 90623, 90630–31, 90637–40, 90650–52, 90659–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844–48, 90853, 90888, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91131, 91182, 91184–85, 91188–89, 91191, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–65, 91367, 91371–72, 91376, 91380–88, 91390, 91392–96, 91399, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–97, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91759, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91797, 91799, 91801–04, 91841, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- Riverside: 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92292, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- San Bernardino: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758, 91761–64, 91766, 91784–86, 91792, 91798, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–

18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880

- San Diego: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 91990, 92007–11, 92013–14, 92018–27, 92029–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–58, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–85, 92090–93, 92096, 92101–24, 92126–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–99
- Ventura: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93093–94, 93099, 93252

Note: We may expand your Home Region's Service Area at any time by giving written notice to your group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.